



*The Commonwealth of Massachusetts  
Commonwealth Health Insurance Connector Authority  
100 City Hall Plaza  
Boston, MA 02108*

CHARLES BAKER  
Governor

MARYLOU SUDDERS  
Board Chair

KARYN POLITO  
Lieutenant Governor

LOUIS GUTIERREZ  
Executive Director

**Board of the Commonwealth Health Insurance Connector Authority**

**Minutes**

Thursday, May 12, 2016  
9:00 AM to 11:00 AM

One Ashburton Place  
Boston, MA 02108  
21<sup>st</sup> Floor Conference Room

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**Attendees:** Louis Gutierrez, Mark Gaunya, Michael Chernew, Louis Malzone, Ray Campbell, Nancy Turnbull, Dimitry Petion, Rina Vertes, Kristen Lepore, Celia Wcislo. Michael Conway attended as the representative of Daniel Judson. Marylou Sudders arrived at 10:30 AM.

The meeting was called to order at 9:05 AM.

Ray Campbell began the meeting, introducing himself as the acting Executive Director of the Group Insurance Commission (GIC). He stated that he would chair this meeting of the Board in place of Secretary Sudders.

- I. Minutes:** The minutes of the March 10, 2016 meeting were approved by all but Mr. Campbell, who abstained because he was not in attendance at the meeting.
- II. Executive Director's Report:** Mr. Gutierrez noted that the Board did not meet in April. He stated that the Health Connector is already planning for the next Open Enrollment period and noted that system implementation activities and business events are planned daily through December. He noted that numerous operational issues remain but are under control. He stated that the Seal of Approval (SOA) discussion on the agenda marks a turn toward engaging in broader policy discussions, as requested by the Board of Directors. He stated that several Health Connector staff members were in Washington, D.C. earlier in the week for the spring meeting of State-based Marketplaces (SBMs) and noted that all SBMs

are planning for the future. Mr. Gutierrez then reviewed enrollment numbers, stating that May 1 membership is steady at 214,894 Qualified Health Plan (QHP) members and that, inclusive of prospective June 1 enrollments, QHP membership is approximately 224,000. He noted that membership is stable as activity from Open Enrollment tapers off and added that MassHealth redeterminations will likely increase Health Connector membership. He then discussed the SOA agenda item, stating that the discussion is not about the immediate SOA but rather about its history and future. He noted that UnitedHealthcare (United) will not be participating in the Exchange this year and added that United is withdrawing from a number of other states as well. He stated that there are fewer than 500 United members enrolled through the Health Connector and ensured that these members will experience a seamless renewal process in the fall. He added that Guardian and MetLife, both small group dental carriers, are also leaving the Exchange. He concluded by stating that the conditional SOA will come before the Board in July.

- III. Introduction to Open Enrollment 2017:** The PowerPoint presentation “Introduction to Open Enrollment 2017” was presented by Rebekah Diamond, Michael Piantanida and Patricia Wada. Ms. Diamond began the presentation by stating that, while it may seem early to be discussing Open Enrollment, the Health Connector is leveraging its renewals experience last year to begin planning earlier this year. She added that there will be several changes to the process this year and that the Health Insurance Exchange/Integrated Eligibility System (HIX/IES) project will execute a substantial development schedule. Ms. Diamond then provided a summary of last year’s Open Enrollment period, stating that the Health Connector retained about 94 percent of its QHP members following the renewals process, exceeding its goal of 90 percent. She added that approximately 36,000 new members were added. She stated that operational processes worked well such that there were no problems with the billing process and customer service remained steady for the duration of Open Enrollment. In response to a question from Ms. Turnbull, Ms. Diamond replied that the Health Connector can provide data on the difference in retention rates between the ConnectorCare and unsubsidized populations. Ms. Diamond then explained the difference between the terms “redetermination” and “renewal,” stating that “redetermination” concerns an individual’s eligibility while “renewal” refers to an existing member’s continued coverage, either by remaining in existing coverage or switching to a different plan. She added that the Affordable Care Act (ACA) requires that enrollees be offered a passive renewal process, meaning that they can continue in existing coverage without taking action. She explained that SBMs can conduct these processes in three ways: follow the federal regulations exactly, follow the Federally Facilitated Marketplace’s (FFM) approach, or develop a state-specific model. She added that the Health Connector is developing a state-specific model to be approved by the Centers for Medicare & Medicaid Services (CMS). In response to a question from Ms. Wcislo, Ms. Diamond replied that this process is separate from the MassHealth redeterminations process. Mr. Gutierrez added that MassHealth redeterminations are ongoing. Ms. Diamond noted that the Health Connector redeterminations and renewals processes are specific to households with at least one enrolled QHP member. She added that some households are mixed, as in they include both Health Connector and MassHealth members, and noted that she would discuss mixed households later in the presentation. Next, Ms. Diamond reviewed the timeline for the redeterminations and renewals processes, stating that preliminary

eligibility occurs in August, followed by a 30-day review period for Health Connector households and a 45-day period for mixed households. She stated that final eligibility occurs in October and that notices are sent after that. She stated that at the end of November, enrollees will be auto renewed into their mapped plan, which will be the same as their current plan or a similar plan if their current plan is no longer available to them. She added that payment for 2017 coverage is due January 1.

Ms. Diamond then reviewed the four major changes to the redeterminations and renewals process this year and noted that these updates are mainly driven by federal requirements. The first, she stated, is the reversion to Internal Revenue Service (IRS) income data; second, the first major batch process to retrieve the Failure to Reconcile (FTR) flag; third, the first use of the Redeterminations and Renewals Validation (RRV) service; and fourth, the first time processing mixed households in HIX/IES. Mr. Gutierrez underscored the importance of these updates, noting that this is not a routine Open Enrollment year and that each of these changes has system building implications. Ms. Turnbull requested that these changes be highlighted from the consumer perspective as they are each discussed. Ms. Diamond first discussed the reversion to IRS income data, stating that a member could see a different Federal Poverty Level (FPL) than the one to which they attested. She explained that if an individual fails to provide verifying documentation and their reported income is not compatible with available income data, the system will revert to IRS income data. She added that this is different from last year's process because last year, since all individuals applied anew the year prior, their projected income was used as it was more recent than the previous year's tax data. She noted that this year's notices highlight the change. In response to a question from Ms. Turnbull, Ms. Diamond stated that premium amounts will not be included in preliminary eligibility notices because plan rates will not yet be available, but noted that preliminary notices will include an individual's program type. In response to a question from Ms. Weislo, Ms. Diamond stated that while the Health Connector encourages individuals to report changes in income year-round, some people may not have updated their income since first creating their application. She added that IRS data will be ignored for members who manually sent in verifying documentation. In response to a question from Mr. Chernew, Ms. Diamond confirmed that IRS data will be overridden if someone manually verifies their income. Ms. Diamond then discussed the second system update, stating that this is the first year the Health Connector will run a large batch process to determine if individuals who received tax credits filed and reconciled their taxes, and that those who failed to file and reconcile will trigger an FTR flag. She noted that very few people received tax credits in 2014, so the FTR check was run on a much smaller population last year. If an individual does not file and reconcile their taxes, she stated, they may lose tax credits in 2017. She stated that the importance of filing and reconciling taxes was communicated to members throughout the year, particularly when the Health Connector sent 1095 forms to its members in January. In response to a question from Ms. Weislo, Ms. Diamond replied that since the FTR flag is Federal Tax Information (FTI), the Health Connector cannot have access to information about an individual's FTR status. She noted that this presents a challenge for Customer Service Representatives (CSRs) working with members who lose their subsidies but do not know why. In response to a question from Mr. Chernew, Ms. Diamond replied that the Health Connector will explore ways to track the experience of individuals who call the call center because they

have lost subsidies due to FTR. Mr. Gutierrez noted again that, because the FTR flag is FTR, a CSR cannot tell an individual if they triggered the FTR flag. Ms. Wcislo noted that this results in a confusing member experience.

Mr. Petion inquired about the Health Connector's efforts to communicate to members the importance of updating income. In response, Ms. Diamond stated that the Health Connector tries to encourage members to update their income year-round via e-mails and paper mailings. In response to a question from Mr. Petion, Ms. Diamond replied that the Health Connector has a very low rate of returned mail. Ms. Diamond continued the presentation, stating that this is the first year the Health Connector will use the RRV service to send batch files to different services. She added that Medicaid is currently using the RRV for its redeterminations and has had success using the service thus far. In response to a question from Ms. Turnbull, Ms. Diamond stated that the Health Connector is switching to the RRV this year because it is a federal requirement. Ms. Diamond then discussed mixed households, defining mixed households as those with at least one individual eligible for Health Connector coverage and one member eligible for MassHealth. She added that the Health Connector has been working in close coordination with MassHealth in developing the process for mixed households. In response to a question from Ms. Wcislo, Ms. Diamond stated that the most common mixed household scenario is a household in which the parents have a ConnectorCare plan and the children are in the Children's Health Insurance Program (CHIP). She added that approximately 40,000 enrollees are in mixed households. In response to a question from Ms. Turnbull, Ms. Diamond replied that the Health Connector has not yet worked with other states that process mixed households but added that the Health Connector can reach out to other states to learn from their experiences. Mr. Gutierrez added that a small number of states have integrated eligibility systems and that Health Connector staff can follow up with those states. In response to a question from Mr. Campbell, Ms. Diamond clarified that the 40,000 mixed household member count includes only households in which there is an enrolled Health Connector member. In response to a question from Mr. Chernew regarding member churn between MassHealth and the Health Connector, Ms. Diamond stated that if an individual reports a change during the year, data sources will be checked depending on which section of the application has been updated. She added that it is a federal requirement to check an individual's income if they have not made any updates manually.

Ms. Diamond then reviewed consumer improvements and consumer support goals for Open Enrollment 2017. She stated that the Health Connector worked with the Maximus Center for Health Literacy (MCHL) to test 20 non-members' understanding of the web user interface. She stated that the Health Connector will make improvements based on feedback received in this process as well as feedback from consumer advocates. She stated that improvements will also be made to the redeterminations and renewals notices to improve clarity and suppress unnecessary or duplicative notices. Ms. Wiclslo noted that many people in the MCHL report stated that they would like to speak to someone in person or by phone if they were confused about the application and added that this underscores the importance of the Health Connector's walk-in centers. In response to a question from Ms. Turnbull, Ms. Diamond answered that MCHL had only English speakers participate in the study because the web user interface is in English. She added that one participant

was a Spanish speaker who also spoke English. In response to a question from Mr. Petion, Mr. Gutierrez stated that a live chat feature on the Health Connector's website is an important consideration in modernizing the site in the future but stated that it is not functionality that can be added this year. In response to a question from Ms. Turnbull, Ms. Diamond stated that the Health Connector uses e-mail for some communications but still sends its legally-required notices on paper. She added that the Health Connector hopes to expand its use of e-mail in the future. Ms. Diamond then reviewed consumer support goals for the next Open Enrollment period and stated that the Health Connector aims to support existing members through the renewals process and communicate to members the importance of updating their information.

Next, Mr. Piantanida discussed systems planning and testing for Open Enrollment 2017. He stated that the Health Connector is developing a comprehensive project plan for testing as well as batch processing. He stated that the project plan is detailed and includes specific dates for the production and execution of key business events. He reviewed the business events that must be executed before and during Open Enrollment, including preliminary eligibility in August, final eligibility in October and auto enrollment in November. He stated that the project plan addresses regulatory guidelines and business dependencies. Mr. Piantanida then explained production-like testing, stating that it is a comprehensive simulation of the renewals process. He added that it replicates the size, scale and complexity of the preliminary eligibility, final eligibility and auto enrollment runs and provides insight into how those processes will run in production. He reviewed an overall timeline for Open Enrollment 2017 to display how all of the system processes and business events are related.

Ms. Wada then reviewed the upcoming system releases for Calendar Year 2016 and early Calendar Year 2017. She stated that five releases were planned for 2016, the first being Release 7.2 following the last Open Enrollment period. She added that the 2016 release schedule will conclude with Release 10.0 in October, prior to the start of Open Enrollment 2017. She discussed the RRV service and noted that MassHealth is currently using the RRV. She stated that a number of system repairs for Open Enrollment 2017 are scheduled for Release 9.0 in August and added that the production-like testing discussed by Mr. Piantanida is included in pre-Open Enrollment releases. In response to a question from Ms. Turnbull regarding systems changes for MassHealth, Ms. Wada stated that HIX/IES, MassHealth and Health Connector staff have been working closely and that planning for changes for both agencies is very tightly integrated. In response to a question from Ms. Turnbull, Ms. Wada replied that the RRV service presents the biggest challenge this year because it is a change to the batch process. She explained that files will be sent to the IRS, Social Security Administration (SSA) and Medicare and that once these files are returned, member information will be updated. Ms. Wada noted that MassHealth is currently seeing files returned quickly using the RRV despite longer Service Level Agreements (SLAs). In response to a question from Ms. Turnbull regarding whether such a quick turnaround is expected to remain, Ms. Wada stated that HIX/IES is working closely with CMS to develop the schedule. In response to a question from Mr. Chernew regarding contingency planning, Mr. Piantanida agreed that the schedule is tight but noted that there is some leeway. For example, Mr. Piantanida stated, if FTR flag batches run longer than anticipated after the

flag becomes available on September 25, there is still some time to catch up as long as all final eligibility notices are mailed by November 1. He added that production-like testing will allow the Health Connector to determine how long it will take batches to run before they are executed in production. Ms. Diamond concluded the presentation by reviewing the key business events leading up to and during Open Enrollment.

- IV. Seal of Approval: Product Strategy Evolution and Current State:** The PowerPoint presentation “Seal of Approval: Product Strategy Evolution and Current State” was presented by Ashley Hague, Audrey Gasteier and Brian Schuetz. Ms. Hague opened the presentation by stating that the discussion will review the evolution of the SOA and how it can be used in the future, specifically for 2018 but also for the years beyond. Mr. Schuetz then discussed the SOA product strategy history, stating that the SOA began in 2007. He noted that the presentation will focus on non-subsidized products and key components of the product portfolio, including choice, simplicity, market trends, consumer support, and technical and operational limitations. He stated that, in 2007, the SOA sought five different types of plans, loosely structured around benefit design and actuarial value (AV). He noted that carriers were allowed to define AV with their actuaries as there was no unified AV calculator. He added that, at this time, the state’s individual mandate took effect, setting Minimum Creditable Coverage (MCC) standards. In response to a question from Ms. Wcislo, Mr. Schuetz answered that AV was defined by plan at that time and therefore varied widely. Mr. Schuetz then reviewed product strategy in 2010 and 2011, stating that the large variation in the first several years led to standardization. He stated that standardization allowed consumers to make “apples-to-apples” comparisons across carriers. He added that, at this time, carriers began to introduce limited networks. Next, Mr. Schuetz stated that flexibility was introduced in the 2012 and 2013 SOA. He stated that, at this time, the Health Connector encouraged innovation from carriers, particularly in the small group market. He noted that the 2013 product shelf resulted in 22 new options for consumers.

Mr. Schuetz then discussed the new requirements introduced in 2014 as a result of the implementation of the ACA. He stated that the ACA placed new requirements on the SOA, the most significant being the movement of the Commonwealth Care program into the merged market. He stated that Commonwealth Care members were moved into Silver tier QHPs, bringing a significant population into the Silver tier and influencing how the Health Connector created its products. He added that dental products were introduced in the marketplace in 2014. Ms. Wcislo added that Commonwealth Care members were also moved into Medicaid at this time. Mr. Schuetz stated that the ACA model included a defined AV calculator and metallic tier definitions. He noted that this marked a substantial shift in AV and compared Health Connector plan AVs pre-ACA and post-ACA. Mr. Chernew noted that the subsidized population does not experience the shift in AVs in the same way as the unsubsidized population. Mr. Schuetz then reviewed the SOA product strategy following the ACA, from 2015 to the current planning for the 2017 SOA. He noted that the 2015-2017 SOA focuses on stabilization after the transition years of the ACA. He stated that goals include streamlining the number of standard designs to one per metallic tier, capping network offerings, supporting apples-to-apples comparison shopping, standardizing product names and leveraging the SOA to address population

health needs. Mr. Schuetz showed a graphic that illustrated product designs over time, noting the growth in plan options prior to the ACA and then a focusing of the plan shelf following the ACA. He continued to review product strategy history and reviewed a graph displaying trends in the number of plans, number of plan designs, number of carriers and non-group unsubsidized enrollment. He noted a growth in the number of plans but a reduction in the number of plan designs and added that this is mainly due to the entry of new carriers to the marketplace. He added that it is difficult to draw a direct correlation between enrollment trends and the number of plans and plan designs. Ms. Wcislo noted that the Health Connector was able to use federal dollars for subsidies which eased the amount of state subsidy money needed. Ms. Hague stated that a significant savings for Massachusetts was the Aliens with Special Status (AWSS) population becoming eligible for tax credits. She added that, prior to the ACA, Massachusetts was paying for those subsidies. Mr. Schuetz then discussed the ConnectorCare program and stated that in 2016, premiums in the merged market increased six percent while the ConnectorCare portion of the Silver tier saw a reduction in premium amount overall. In response to a question from Mr. Chernew, Mr. Schuetz replied that risk adjustment is conducted across all market segments and Ms. Vertes clarified that risk adjustment includes the small group market.

Ms. Gasteier then discussed the history of consumer shopping and decision support on the Exchange. She noted that decision support was different pre- and post-ACA and stated that, prior to the ACA, tools were available to Commonwealth Choice members that allowed consumers to indicate preferences such as providers, deductibles and metallic tiers. She stated that, currently, basic filtering is available by carrier, metallic tier and core plan design features and that the provider search tool is available but only for hospitals and physicians. She stated that the Health Connector would like to expand decision support tools to include cost estimation, cost exposure, quality metrics, formulary search and advanced provider selection tools. She stated that the Health Connector is looking to other SBMs for decision support ideas and added that Health Connector staff welcome insights from the Board on this topic. Mr. Malzone expressed concern that the product shelf is too complicated and is not consumer friendly. Mr. Gaunya applauded the focus on decision support and stated that the most important considerations when a consumer chooses a plan are whether their doctor is in the network, the cost of the premium and out-of-pocket costs. He stated that many choices can be overwhelming but noted that we can use technology to focus the number of options consumers see when choosing a plan. Mr. Petion commented on the importance of incorporating behavioral health providers into decision support tools. Mr. Schuetz agreed and stated that behavioral health providers are an important provider type to be included in a future version of the provider search tool. Mr. Chernew noted that risk is also an important consideration when a consumer selects a health plan. He added that standardization helps competition but that there are also a lot of reasons to allow different plan designs on the shelf. Mr. Gaunya expressed that it is important to explore telehealth and added that telehealth will improve access to behavioral health providers and can remove the social stigma of visiting a behavioral health provider's physical office. Mr. Campbell commented on the many similarities between the Health Connector and the GIC. He stated that the GIC has significant experience in benefit design and would be interested in working with the Health Connector in areas of overlap such as benefit design and consumer tools. In response to a question from Ms. Turnbull, Mr. Campbell answered that

the GIC offers 17 products through six carriers and that the average state worker has 11 products available to them. Ms. Wcislo posed the idea of moving the GIC population into group health insurance coverage. Ms. Turnbull remarked that there is a large body of research regarding how consumers make good and valuable choices. She stated that she would like to understand the research base on the topic of the appropriate number of choices for consumers. She added that several other SBMs have been limiting choices. She noted that the Health Connector serves less than one percent of the small employer market and that it will be important to discuss the Health Connector's future goals in the small group market.

Mr. Schuetz then compared Massachusetts' product offerings to those of other SBMs. He explained that other states have varying ways of selecting plans and that 40 states use the minimum federal threshold criteria. He added that other states, as well as the FFM, are offering structure and standardization. Ms. Gasteier stated that California recently launched a quality-driven initiative with health insurance carriers with a seven-year implementation plan. She added that other quality initiatives focus on health disparities with respect to diabetes and hypertension. Ms. Wcislo stated that it would be useful to let consumers know which plans offer the best coverage for diabetics. Mr. Chernew remarked that in standard plan definitions, there is no clinical nuance for specific diseases but that many organizations are building plans that address certain diseases. Mr. Schuetz stated that Massachusetts has more carriers, on average, than other states, contributing to the number of products offered by the Exchange. Ms. Turnbull added that many of the carriers in Massachusetts are locally based. Ms. Gasteier then reviewed two pie charts showing enrollment by carrier on and off of the Exchange, noting that the comparison illuminates different competitive dynamics. Ms. Turnbull noted the most striking difference as Blue Cross Blue Shield enrollment inside and outside of the exchange, and Ms. Vertes noted that the difference in the total number of enrollees in each chart is likely significant. Ms. Hague summarized the graphics by stating that, inside the Exchange, consumers can compare all carriers side-by-side, allowing for direct comparisons of price and provider network. Outside of the Exchange, she stated, it is not as easy to make direct comparisons. Ms. Gasteier concluded the presentation by stating that the Health Connector continually considers the next chapter of the SOA and will incorporate feedback from Section 1332 discussions and make improvements to decision support tools. She added that the Health Connector hopes to use data from the All Payer Claims Database (APCD) to better understand the needs of its members. In response to a question from Ms. Turnbull, Mr. Gutierrez stated that the Small Business Health Options Program (SHOP) is a challenge and that the Health Connector has engaged a third party to review SHOP options given constraints in the Massachusetts market and employee choice requirements. He added that he will provide the Board with an update in the coming months. Ms. Hague concluded in stating that Health Connector staff will continue to engage the Board in discussions about the future of the SOA.

The meeting was adjourned at 10:52 AM.

Respectfully submitted,  
Maria H. Joy